Personalised Integrated Care in the UK

World Health Organisation – Global consultation for integrated care for older people

The challenges

The risk stratification criteria	Post implementation, the risk stratification criteria were expanded to better reflect local context, demand and need, yet it still retained a focus on a high-need, high-cost cohort of older people. Common to every Phase 2 site was the expansion of the criteria to include older people with one or more hospital admissions. The findings highlight the tension between a targeted service model, which aims to deliver in-year cost savings for the health and care system, with a more wide-reaching or 'earlier prevention' service that might better meet local need or demand but for which impact on acute care utilisation in particular could take longer to become apparent.
Engaging General Practitioners (GPs)	Securing genuine GP involvement consistently across 'the patch' has been challenging for sites delivering the service through individual practices. The barriers to GP engagement have been inextricably linked and are not unique to this programme: lack of capacity; lack of understanding and appreciation of the quality and potential value of the support offered through the programme; concern about sharing patient information; and the pilot status. While the breadth and efficacy of the action taken across the Phase 2 sites has varied, all have taken steps to support GP engagement. For most, it has increased during the pilot. However, many stakeholders identified the need to further embed the programme within primary care as being critical to its sustainability.
Involving volunteers	For all local Age UKs involved in Phase 2, recruiting volunteers, and having a timely pool of volunteers who match clients' needs has been difficult. Only four sites have used dedicated programme volunteers. Workforce models to address the challenges associated with involving volunteers in the programme, while retaining the value they add with respect to improving financial sustainability and clients' wellbeing have been explored – including the introduction of a support worker.
Addressing gaps in the community offer	Investing time in mapping and continually exploring community assets beyond wider Age UK services, and including statutory services, throughout all phases of the programme has been critical. However, for some clients, 'what's available' does not always meet their needs and preferences – this can limit the extent to which they make changes to improve their wellbeing. Given the duration of the pilot, few sites have sought to address gaps in the existing local community offer. Stakeholders from several sites highlighted the need to exploring the feasibility of establishing new, sustainable community offers that might better meet some clients' needs.
Tracking outcomes for the health system locally	Difficulties in accessing NHS Hospital Episode Statistics data have limited Phase 2 sites' ability to track and evidence outcomes in a timely way and created a dependency on the programme level impact evaluation being undertaken by the Nuffield Trust. They have also increased dependency on GPs to create the risk stratified lists of eligible older people. The barriers have largely be due to national and local Information Governance protocols and NHS capacity issues.

Lessons Learned

Case finding

•**A combination of proactive and reactive case finding involving clinical judgement has proved critical to creating sufficient demand for the programme and equality of access.** The approach has enabled the identification of older people who are not visible to the statutory health and care system, as well as those who are at crisis point and on the radar of the GPs and other health care professionals.

▪**Cohort growth plans need to acknowledge older peoples' choice and address the barriers they could face to joining the programme and uptake / retention rates**. On average 25% of clients meeting the criteria and referred over the lifetime of the programme decline the offer to become involved.

The findings from the qualitative research with clients strongly suggest a combination of factors can prevent older people from wanting to become involved:

–Reluctance to accept help
–Feeling bombarded by the attentions of health and care professionals and wanting some 'normality' in their lives
–A lack of understanding of the service and/or preconceptions about Age UK.

In some cases, clients have proved more receptive to the invitation to take part in the programme if their GP, as someone they trust, made the introduction verbally, in addition to sending the initial invite letter. The findings also underlines the need for Age UK Personal Independence Co-ordinators (PICs) to be skilled enough to begin to gently overcome any barriers during the initial telephone contact with potential clients.

Multi-Disciplinary Team (MDT) working and case review

▪**The extent to which Age UK PICs have become embedded within MDTs has varied across and within sites.** Common factors that have driven and hindered involvement in include:

–The existence and maturity of the local MDT infrastructure and culture
–The perceived value of the support that Age UK can provide to older people
–The skills and credibility of Age UK PICs.

▪**Case review by a MDT has not take place for all client**s. The relatively low-level and short-term goals and needs identified by some clients have not warranted a MDT discussion. Additionally, patients who do not have acute needs and/or are not at or close to crisis point are unlikely to be discussed given the criteria and priorities for many MDT meetings.

Personalised shared care planning and a single care plan

▪**Reflecting the timescales of the pilots, the focus has been on facilitating and enabling personalised care and support planning**,

Facilitating integrated care through the use of a single care plan has not been possible in the time frame of pilot – not least because of the dependency on the existence of interoperable IT systems that allows different health and care professionals to access a shared care plan

The absence of a single shared care plan has not prevented personalised shared care planning, which has taken place at several levels. The goal oriented plan co-produced between the Age UKPIC and the older person is shared with each client's GP. For those clients who are discussed in an MDT setting, the Age UK PIC articulates the clients needs and preferences when planning care with other health and care professionals.

Programme and team management

▪**Managing the programme locally requires knowledge, skills and expertise in:**

–The needs, ways of working and culture of the various partners involved
–Engaging effectively with and navigating the Voluntary and Community Sector (VCS), Clinical Commissioning Groups, NHS and local authorities
–Building and maintaining relationships and influencing delivery partners to co-produce and co-deliver change
–Strategic and operational service planning and improvement.

In practice, strategic programme management has been shared to varying degrees across the lifetime of the Phase 2 between a senior Age UK programme manager and programme manager from the health and care system. The latter's knowledge and experience of the health system's processes, practices, ways of working and culture have complemented the Age UK programme manager's expertise in the VCS and knowledge and experience of supporting older people to live well.

▪**An operational Age UK team leader to performance-manage and support the Age UK team and volunteers has also proved essential.** Without such an Age UK team leader in place, there is the risk that the programme manager role could be compromised and PICs may not be supported effectively and efficiently.

▪**The role of the Age UK PICs is a challenging one and requires competencies in**:

–Building trusting relationships with clients and listening to, supporting and empowering them to identify and achieve goals or improve their quality of life – rather than adopting a 'fixer role'
–Building relationships and integrating with statutory health and care professional teams and gaining the confidence of primary care and other healthcare stakeholders.

Active local performance management to maximise success

•**At a local level, additional support, resource and time is likely to be needed to maximise the benefits of the data captured through the programme's output and performance framework.** Effective approaches taken by local teams include:

–Recruiting a data analyst with the expertise in bringing to life the data for different audiences
–Ensuring there are mechanisms in place to reflect and discuss progress, what is working well and less well, and potential solutions to address issues.

The national monthly learning forum, a community of practice for those involved in the programme, and health checks at key stages have proved effective in facilitating the exchange of knowledge and taking stock of performance to support continuous improvement.

Programme level performance management and evaluation

▪**Ensure effective mechanisms are in place to support active performance management.** Monthly output and quarterly outcome performance reporting has supported performance management. However, variation in the quality and consistency of the data provided by local sites has highlighted the complexities of defining, cleaning and processing outcome, activity and cost data in order to create a robust picture of programme performance.

▪**Embed formative and summative evaluation from the outset**, combining qualitative and quantitative approaches to understand whether and how the programme is on track to identify lessons learned to support continuous improvement along the way, and to understand the impact of the programme – going beyond what works, and exploring what works for whom and in what circumstances.

▪**One year's operation is insufficient to 'stabilise' delivery of the model**. Evaluation of impact after 12 months is therefore likely to capture only the impact of implementation – longitudinal evaluation is essential.